FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037960

Facility Name: COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.

Address: 901 SOUTH AUSTIN (Number) CHICAGO (City) 60644 (Zip Code)

County: COOK

Telephone Number: (773) 287-5959 **Fax #** (773) 287-7909

IDPA ID Number: 36-3801333

Date of Initial License for Current Owners: 1/1/92

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL		
	Charitable Corp.		Individual		State		
	Trust		Partnership		County		
IRS Exemption Code			Corporation		Other		
		X	"Sub-S" Corp.				
			Limited Liability Co.				
			Trust				
			Other				

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)
(Print Name and Title) CARY C. BUXBAUM, C.P.A.
(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,528	1
2		Skilled Pediatric (SNF/PED)			2
3	108	Intermediate (ICF)	108	39,528	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	216	TOTALS	216	79,056	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,500	246	3,673	17,419	8
9	SNF/PED					9
10	ICF	53,996	986		54,982	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	67,496	1,232	3,673	72,401	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.58%

D. How many bed-hold days during this year were paid by Public Aid?
2,721 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/ 01/92

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/92 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 19 and days of care provided 1,112

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABII # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	190,018	25,364	37,340	252,722		252,722	(10,166)	242,556			1
2	Food Purchase		277,299		277,299	(25,254)	252,045	(47)	251,998			2
3	Housekeeping	144,646	23,617		168,263		168,263	635	168,898			3
4	Laundry	70,644	33,191		103,835		103,835		103,835			4
5	Heat and Other Utilities			181,290	181,290		181,290	2,379	183,669			5
6	Maintenance	37,840	10,037	150,420	198,297		198,297	(42,630)	155,667			6
7	Other (specify):*							4,569	4,569			7
8	**TOTAL General Services**	443,148	369,508	369,050	1,181,706	(25,254)	1,156,452	(45,260)	1,111,192			8
	B. Health Care and Programs											
9	Medical Director			6,300	6,300		6,300		6,300			9
10	Nursing and Medical Records	1,487,392	111,726	574,578	2,173,696		2,173,696	(47,123)	2,126,573			10
10a	Therapy	128,612		6,874	135,486		135,486		135,486			10a
11	Activities	81,506	7,448	3,918	92,872		92,872		92,872			11
12	Social Services	49,087		3,247	52,334		52,334		52,334			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							3,441	3,441			15
16	**TOTAL Health Care and Programs**	1,746,597	119,174	594,917	2,460,688		2,460,688	(43,682)	2,417,006			16
	C. General Administration											
17	Administrative	107,878		533,343	641,221		641,221	(335,346)	305,875			17
18	Directors Fees											18
19	Professional Services			169,349	169,349		169,349	(91,891)	77,458			19
20	Dues, Fees, Subscriptions & Promotions			64,995	64,995		64,995	(8,633)	56,362			20
21	Clerical & General Office Expenses	66,222	30,813	135,355	232,390		232,390	(42,622)	189,768			21
22	Employee Benefits & Payroll Taxes			360,116	360,116	25,254	385,370		385,370			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,053	3,053		3,053	820	3,873			24
25	Other Admin. Staff Transportation			533	533		533	3,470	4,003			25
26	Insurance-Prop.Liab.Malpractice			82,497	82,497		82,497	1,071	83,568			26
27	Other (specify):*							26,342	26,342			27
28	**TOTAL General Administration**	174,100	30,813	1,349,241	1,554,154	25,254	1,579,408	(446,789)	1,132,619			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,363,845	519,495	2,313,208	5,196,548		5,196,548	(535,731)	4,660,817			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.
0037960
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	25,254	
2	FOOD		25,254

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CEN#0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			68,279	68,279		68,279	21,698	89,977			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,693	21,693		21,693	4,642	26,335			32
33	Real Estate Taxes			152,098	152,098		152,098	4,856	156,954			33
34	Rent-Facility & Grounds			1,044,630	1,044,630		1,044,630	(9,126)	1,035,504			34
35	Rent-Equipment & Vehicles			6,195	6,195		6,195	10,001	16,196			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,292,895	1,292,895		1,292,895	32,071	1,324,966			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		44,544	55,870	100,414		100,414	(8,971)	91,443			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			118,584	118,584		118,584		118,584			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		44,544	174,454	218,998		218,998	(8,971)	210,027			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,363,845	564,039	3,780,557	6,708,441		6,708,441	(512,631)	6,195,810			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION C # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	12,788	30		9
10	Interest and Other Investment Income	(14)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(47)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(83,269)	21		24
25	Fund Raising, Advertising and Promotional	(2,587)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(13,869)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(6,381)	20		28
29	Other-Attach Schedule	(52,408)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (145,787)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(366,844)	VARIOUS	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (366,844)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (512,631)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.

ID# 0037960

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$ 2,292	6	1
2	Veterans Prescrip Drugs	(5,950)	10	2
3	Veterans Expense	(1,216)	10	3
4	Trust Fees	(150)	20	4
5	Collection Fees	(232)	21	5
6	Tower Income	(8,250)	34	6
7	Telephone	(876)	34	7
8	C.N.A. Salary (Jury Duty Pay)	(34)	10	8
9	Dues "COPE"	(279)	20	9
10	Prior Year Ancillary Expense	(6,550)	39	10
11	Prior Year Management Fees	(909)	17	11
12	Capitalized Repairs & Maintenance	(29,469)	6	12
13	City Personal Property Tax	(785)	20	13
14				14
15				15
16				16
17				17
18				18
19				19
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86				86
87				87
88				88
89				89
90	Total	(52,408)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CE # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary					(22,515)			12,349				(10,166)	1
2	Food Purchase	(47)											(47)	2
3	Housekeeping			635									635	3
4	Laundry													4
5	Heat and Other Utilities			858	1,521								2,379	5
6	Maintenance	(27,177)		529	(12,273)	(3,709)							(42,630)	6
7	Other (specify):*				816	3,753							4,569	7
8	**TOTAL General Services**	(27,224)		2,022	(9,936)	(22,471)			12,349				(45,260)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(7,200)			(22,438)				(17,485)				(47,123)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				3,441								3,441	15
16	**TOTAL Health Care and Programs**	(7,200)			(18,997)				(17,485)				(43,682)	16
	C. General Administration													
17	Administrative	(909)		14,836	(67,708)	(286,653)		5,088					(335,346)	17
18	Directors Fees													18
19	Professional Services			(89,703)	(15,001)	12,795		18					(91,891)	19
20	Fees, Subscriptions & Promotions	(10,182)		382	1,155			12					(8,633)	20
21	Clerical & General Office Expenses	(97,370)		49,262	5,460			26					(42,622)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			194	626								820	24
25	Other Admin. Staff Transportation			675	2,795								3,470	25
26	Insurance-Prop.Liab.Malpractice			433	616			22					1,071	26
27	Other (specify):*			7,739	5,155	12,901		547					26,342	27
28	**TOTAL General Administration**	(108,461)		(16,182)	(66,902)	(260,957)		5,713					(446,789)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(142,885)		(14,160)	(95,835)	(283,428)		5,713	(5,136)				(535,731)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CE # 0037960 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	12,788		3,162	5,748								21,698	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(14)		1,234	3,405			17					4,642	32
33	Real Estate Taxes			1,596	3,260								4,856	33
34	Rent-Facility & Grounds	(9,126)											(9,126)	34
35	Rent-Equipment & Vehicles			2,729	6,960			312					10,001	35
36	Other (specify):*													36
37	**TOTAL Ownership**	3,648		8,721	19,373			329					32,071	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(6,550)							(2,421)				(8,971)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(6,550)							(2,421)				(8,971)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(145,787)		(5,439)	(76,462)	(283,428)		6,042	(7,557)				(512,631)	45

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PREFERRED BOOKKEEPING	100.00%	$ 635	$ 635	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	858	858	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	529	529	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	14,836	14,836	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,973	1,973	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	382	382	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	49,262	49,262	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	194	194	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	675	675	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	433	433	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	7,739	7,739	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	3,162	3,162	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	1,234	1,234	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	1,596	1,596	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,729	2,729	29
30	V								30
31	V								31
32	V	19	ACCOUNT./BOOKKEEPING	91,676	PREFERRED BOOKKEEPING	100.00%		(91,676)	32
33	V	19	COMPUTER	5,184	PREFERRED BOOKKEEPING	100.00%	5,184		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 96,860			$ 91,421	$ * (5,439)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.I.R. MANAGEMENT, INC.	100.00%	$ 1,521	$ 1,521	15
16	V	6	REPAIRS AND MAINT.	19,440	S.I.R. MANAGEMENT, INC.	100.00%	7,167	(12,273)	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	816	816	17
18	V	10	NURSING	42,768	S.I.R. MANAGEMENT, INC.	100.00%	20,330	(22,438)	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,441	3,441	19
20	V	17	ADMINISTRATIVE	75,816	S.I.R. MANAGEMENT, INC.	100.00%	8,108	(67,708)	20
21	V	19	PROFESSIONAL FEES	17,496	S.I.R. MANAGEMENT, INC.	100.00%	2,495	(15,001)	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	1,155	1,155	22
23	V	21	CLERICAL & GENERAL	22,032	S.I.R. MANAGEMENT, INC.	100.00%	27,492	5,460	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	626	626	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	2,795	2,795	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	616	616	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	5,155	5,155	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	5,748	5,748	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,405	3,405	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,260	3,260	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	6,960	6,960	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 177,552			$ 101,090	$ * (76,462)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 22,032	S.I.R. MANAGEMENT, INC.	100.00%	$ 5,870	$ (16,162)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	988	988	16
17	V	17	ADMIN./LEGAL SALARIES	380,298	S.I.R. MANAGEMENT, INC.	100.00%	93,645	(286,653)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	12,795	12,795	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	12,901	12,901	19
20	V								20
21	V								21
22	V	10A	SPECIAL REHAB	0	S.I.R. MANAGEMENT, INC.	100.00%	0		22
23	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	0		23
24	V								24
25	V								25
26	V	6	REPAIRS AND MAINT.	12,200	S.I.R. MANAGEMENT, INC.	100.00%	8,491	(3,709)	26
27	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,478	1,478	27
28	V								28
29	V								29
30	V	1	DIETICIAN SALARIES	13,800	S.I.R. MANAGEMENT, INC.	100.00%	7,447	(6,353)	30
31	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,287	1,287	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 428,330			$ 144,902	$ * (283,428)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 73,001	$ 73,001	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	73,001	CCS EMPLOYEE BENEFIT GROUP	100.00%		(73,001)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 73,001			$ 73,001	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	ECM OWNERS COUNCIL	100.00%	$ 18	$ 18	15
16	V	20	DUES, FEES & SUBSCRIPTIONS		ECM OWNERS COUNCIL	100.00%	12	12	16
17	V	21	CLERICAL		ECM OWNERS COUNCIL	100.00%	26	26	17
18	V	26	INSURANCE		ECM OWNERS COUNCIL	100.00%	22	22	18
19	V	32	INTEREST		ECM OWNERS COUNCIL	100.00%	17	17	19
20	V	35	VEHICLE RENTAL		ECM OWNERS COUNCIL	100.00%	312	312	20
21	V	17	MANAGEMENT FEES	4,320	ECM OWNERS COUNCIL	100.00%		(4,320)	21
22	V								22
23	V	17	ADMIN. SAL. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	9,408	9,408	23
24	V	27	EMP. BEN. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	547	547	24
25	V	17	ADMIN. SALARY		ECM OWNERS COUNCIL	100.00%	0		25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,320			$ 10,362	$ * 6,042	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	ENTERAL EQUIPMENT	$ 2,891	PARAMOUNT HEALTH CARE SYSTEMS	100.00%	$ 470	$ (2,421)	15
16	V	10	ENTERAL EQUIPMENT	18,701	PARAMOUNT HEALTH CARE SYSTEMS	100.00%	1,216	(17,485)	16
17	V	1	NUTRITIONAL SUPPLEMENTS		PARAMOUNT HEALTH CARE SYSTEMS	100.00%	12,349	12,349	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 21,592			$ 14,035	$ * (7,557)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COLUMBUS PARK NURSING & REHAB # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ERIC ROTHNER	Stockholder	Administrative	3.77%	SEE ATTACHED	0.71	0.99%	Alloc.Sal.SIR	$ 7,536	17/7	1
2	BRYAN BARISH	Stockholder	Administrative	14.39%	SEE ATTACHED	5.07	10.14%	Alloc.Sal.SIR	29,597	17/7	2
3	NOAH WOLFF	Stockholder	Administrative	4.25%	SEE ATTACHED	0	0%	Mgmt. Fee	36,000	17/3	3
4	LOUISE BERGTHOLD	Stockholder	Administrative	4.25%	SEE ATTACHED	6.19	11.25%	Alloc.Sal.SIR	19,148	17/7	4
5	MIKE GIANNINI	Relative	Administrative	6.60%	SEE ATTACHED	4.51	9.02%	Alloc.Sal.SIR	27,074	17/7	5
6	NENITA GUZMAN	Stockholder	Dietary	1.89%	SEE ATTACHED	6.19	11.25%	Alloc.Sal.SIR	5,870	1/7	6
7	ARTURO ROMINIQUIT	Relative	Clerical	0%	SEE ATTACHED	4.17	10.43%	Alloc.Pfd Bk	2,282	21/7	7
8	TOM WINTER	Stockholder	Administrative	0.94%	SEE ATTACHED	6.26	10.43%	Alloc.Pfd Bk	14,836	17/7	8
9	LEO FEIGENBAUM	Stockholder	Administrative	13.21%	SEE ATTACHED	1	1.67%	Mgmt. Fee	36,000	17/3	9
10											10
11											11
12											12
13								TOTAL	$ 178,343		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION (# 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION (# 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREFERRED BOOKEEPING SERVICES
Street Address: 4100 WEST PRATT AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 674-5200
Fax Number: (847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	878,492	11	$ 6,088	$	91,676	$ 635	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	878,492	11	8,220		91,676	858	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	878,492	11	5,069		91,676	529	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	878,492	11	142,165	142,165	91,676	14,836	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	878,492	11	18,910		91,676	1,973	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	878,492	11	3,657		91,676	382	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	878,492	11	472,061	403,426	91,676	49,262	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	878,492	11	1,858		91,676	194	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	878,492	11	6,465		91,676	675	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	878,492	11	4,146		91,676	433	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	878,492	11	74,163		91,676	7,739	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	878,492	11	30,298		91,676	3,162	12
13	32	INTEREST	BOOK./ACCNT.INCOME	878,492	11	11,823		91,676	1,234	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	878,492	11	15,297		91,676	1,596	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	878,492	11	26,147		91,676	2,729	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						5,184	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 826,367	$ 545,591		$ 91,421	25

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION (# 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization S.I.R. MANAGEMENT, INC.
Street Address 6840 N. LINCOLN
City / State / Zip Code LINCOLNWOOD, IL. 60712
Phone Number (847) 675 -7979
Fax Number (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	642,911	10	$ 13,508	$	72,401	$ 1,521	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	642,911	10	63,644	42,834	72,401	7,167	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	642,911	10	7,250		72,401	816	3
4	10	NURSING	PATIENT DAYS	642,911	10	180,529	180,529	72,401	20,330	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	642,911	10	30,553		72,401	3,441	5
6	17	ADMINISTRATIVE	PATIENT DAYS	642,911	10	71,994	71,994	72,401	8,108	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	642,911	10	22,153		72,401	2,495	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	642,911	10	10,256		72,401	1,155	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	642,911	10	244,124	177,193	72,401	27,492	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	642,911	10	5,556		72,401	626	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	642,911	10	24,821		72,401	2,795	11
12	26	INSURANCE	PATIENT DAYS	642,911	10	5,468		72,401	616	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	642,911	10	45,778		72,401	5,155	13
14	30	DEPRECIATION	PATIENT DAYS	642,911	10	51,045		72,401	5,748	14
15	32	INTEREST	PATIENT DAYS	642,911	10	30,234		72,401	3,405	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	642,911	10	28,948		72,401	3,260	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	642,911	10	61,803		72,401	6,960	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 897,664	$ 472,550		$ 101,090	25

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION (# 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization S.I.R. MANAGEMENT, INC.
Street Address 6840 N. LINCOLN
City / State / Zip Code LINCOLNWOOD, IL. 60712
Phone Number (847) 675 -7979
Fax Number (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	642,911	10	$ 52,122	$ 52,122	72,401	$ 5,870	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	642,911	10	8,770		72,401	988	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	642,911	10	831,558	831,558	72,401	93,645	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	642,911	10	113,620		72,401	12,795	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	642,911	10	$ 114,558	$	72,401	$ 12,901	5
6										6
7										7
8	10A	SPECIAL REHAB	SPECIAL REHAB INC.	82,944	4	56,277	56,277			8
9	15	EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	82,944	4	$ 9,470	$		$	9
10										10
11										11
12	6	REPAIRS AND MAINT.	MAINTENANCE INC.	237,604	10	165,366	165,366	12,200	8,491	12
13	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	237,604	10	$ 28,790	$	12,200	$ 1,478	13
14										14
15										15
16	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	67,672	67,672	13,800	7,447	16
17	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	11,698		13,800	1,287	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,459,901	$ 1,172,995		$ 144,902	25

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION (# 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 73,001	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 73,001	25

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION (# 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ECM OWNERS COUNCIL
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 676-2026
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ECMOC MGMNT FEE INC.	96,000	9	$ 400	$	4,320	$ 18	1
2	20	DUES, FEES & SUBSCRIPTION	ECMOC MGMNT FEE INC.	96,000	9	264		4,320	12	2
3	21	CLERICAL	ECMOC MGMNT FEE INC.	96,000	9	579		4,320	26	3
4	26	INSURANCE	ECMOC MGMNT FEE INC.	96,000	9	496		4,320	22	4
5	32	INTEREST	ECMOC MGMNT FEE INC.	96,000	9	374		4,320	17	5
6	35	VEHICLE RENTAL	ECMOC MGMNT FEE INC.	96,000	9	6,931		4,320	312	6
7										7
8										8
9	17	ADMIN. SAL. - M. GIANNINI	ADMIN. HOURS	39	9	81,858	81,858	5	9,408	9
10	27	EMP. BEN. - M. GIANNINI	ADMIN. HOURS	39	9	4,762		5	547	10
11	17	ADMIN. SALARY	DIRECT ALLOCATION							11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 95,664	$ 81,858		$ 10,362	25

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION (# 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization PARAMOUNT HEALTH CARE SYSTEMS
Street Address 6300 OAKTON
City / State / Zip Code MORTON GROVE, IL 60053
Phone Number (847)470-4700
Fax Number (847)470-4718

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	ENTERAL EQUIPMENT	DIRECT ALLOCATION						470	1
2	10	ENTERAL EQUIPMENT	DIRECT ALLOCATION						1,216	2
3	1	NUTRITIONAL SUPPLEMENTS	DIRECT ALLOCATION						12,349	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 14,035	25

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION (# 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION (# 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION (# 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number COLUMBUS PARK NURSING & REHABIl # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	GRAND NAT'L BANK		X	LINE OF CREDIT	$15,703.00	4/15/98	345,000		4/15/00	8.5000	874	6
7	CIB Bank/S.I.R. Line		X	WORKING CAPITAL				390,000			20,819	7
8												8
9	TOTAL Facility Related				$15,703.00		$ 345,000	$ 390,000			$ 21,693	9
	B. Non-Facility Related*											
10	Supplemental Schedule										4,656	10
11	INTEREST REVENUE										(14)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 4,642	14
15	TOTALS (line 9+line14)						$ 345,000	$ 390,000			$ 26,335	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILIT # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	ALLOCATION FROM:						$	$			$	1
2	PREFERRED BKKG	X									1,234	2
3	S.I.R.MANAGEMENT	X									3,405	3
4	ECM OWNERS COUNCIL	X									17	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 4,656	21

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	159,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	158,154	2
3. Under or (over) accrual (line 2 minus line 1).	$	(846)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	157,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	156,954	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	148,602	8
	1996	152,258	9
	1997	151,642	10
	1998	154,334	11
	1999	153,298	12

1999 BILL = $153.298 x 1.03 =157,897. ROUNDED TO $157,800

ALLOCATION FROM PREFERRED BKKG - $1,596

ALLOCATION FROM S.I.R. MANAGEMENT - $3,260

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,685 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 6

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1992	51,845	1,706	20	2,592	886	21,948	9
10	Various			1993	71,558	1,531	20	3,579	2,048	28,634	10
11	Various			1994	46,784	750	20	2,339	1,589	15,741	11
12	Various			1995	131,277	3,780	20	6,662	2,882	37,199	12
13	MINI BLINDS			1996	610		20	31	31	127	13
14	REHAB ROOM RENOVATIO			1996	36,200	928	20	1,810	882	9,050	14
15	ROOF ADDITION			1996	2,753	71	20	138	67	632	15
16	VINYL TILE REHAB ROO			1996	3,191	351	20	160	(191)	787	16
17	WINDOW TINTING			1996	2,988	340	20	149	(191)	683	17
18	AMCON-A/C			1996	8,775	225	20	439	214	1,976	18
19	CUBICLE CURTAINS			1996	441		20	22	22	95	19
20	CARPETING			1996	1,370	150	20	69	(81)	287	20
21	TUCKPOINTING			1996	5,800	149	20	290	141	1,281	21
22	TUCKPOINTING			1997	5,250	135	20	263	128	942	22
23	NEW ROOF			1997	28,553	732	20	1,428	696	5,117	23
24											24
25	PAGE 12-1 REP TOTALS				89,528	3,701		3,483	(218)	19,671	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33	PAGE 12C TOTALS				25,893			771	771	771	33
34	PAGE 12B TOTALS				273,858	10,771		13,648	2,877	22,078	34
35	PAGE 12A TOTALS				398,077	21,985		19,908	(2,077)	48,951	35
36	TOTAL (lines 4 thru 35)				$ 1,184,751	$ 47,305		$ 57,781	$ 10,476	$ 215,970	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WOOD FENCE			1997	4,150	319	20	208	(111)	728	9
10	REALIGN LAUNDRY CHUT			1997	2,524	65	20	126	61	452	10
11	SHOWER ROOM TILES			1998	35,130	901	20	1,757	856	4,393	11
12	VALANCE/WINDOW			1998	23,077	4,431	20	1,154	(3,277)	2,885	12
13	CARPETING			1998	1,385	266	20	69	(197)	155	13
14	WINDOW TREATMENT			1998	4,852	932	20	243	(689)	547	14
15	A/C REPAIR			1998	1,711		20	86	86	215	15
16	FIRE DAMPERS			1998	32,677	838	20	1,634	796	3,404	16
17	BOILER REPAIR			1998	1,291		20	65	65	195	17
18	FANS			1998	1,360		20	68	68	181	18
19	REWIRING & SPEAKERS			1998	1,940		20	97	97	283	19
20	BOILER PUMPS			1998	3,736	96	20	187	91	452	20
21	PAINTING & WALLPAPER			1998	14,500	372	20	725	353	1,510	21
22	TILES			1998	82,368	2,112	20	4,118	2,006	10,638	22
23	WALL PAPERING			1998	65,400	1,677	20	3,270	1,593	7,358	23
24	ELEVATOR WORK			1998	17,123	439	20	856	417	2,425	24
25	ELEVATOR WORK			1998	2,770	71	20	139	68	394	25
26	STORM BASIN			1998	1,500		20	75	75	156	26
27	HAND & CRASH RAILS			1998	36,125	926	20	1,806	880	4,515	27
28	A/C REPAIR			1998	1,532		20	77	77	199	28
29	TUCKPOINT & CAULK			1998	2,250		20	113	113	311	29
30	CARPETING			1998	5,416		20	271	271	641	30
31	FIRE ALARM			1998	1,940		20	97	97	243	31
32	BOILER REPAIR			1998	1,655		20	83	83	187	32
33	WOLF ROOFING			1998	8,300	213	20	415	202	934	33
34	WINDOW TREATMENTS			1998	30,695	5,894	20	1,535	(4,359)	3,965	34
35	REMODEL N.STATION			1998	12,670	2,433	20	634	(1,799)	1,585	35
36	TOTAL (lines 4 thru 35)				$ 398,077	$ 21,985		$ 19,908	$ (2,077)	$ 48,951	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	HANDRAILS,CRASH RAIL			1998	18,720	480	20	936	456	2,106	9
10	WOLF ROOFING			1998	4,000	103	20	200	97	450	10
11	INSTALL WALL BASE			1998	5,544	142	20	277	135	623	11
12	PLUMBING WORK			1999	3,573	92	20	179	87	343	12
13	WALLPAPER ELEVATOR			1999	1,818		20	91	91	137	13
14	TUCKPOINTING			1999	1,350		20	68	68	79	14
15	ELECTRICAL WIRING			1999	2,470		20	124	124	176	15
16	DOORS			1999	2,376		20	119	119	238	16
17	ELEVATOR WORK			1999	2,780	71	20	139	68	209	17
18	MIRROR OVERLAYS			1999	1,012		20	51	51	85	18
19	PAINTING			1999	29,100	746	20	1,455	709	2,668	19
20	PIPE AND WIRE			1999	1,395		20	70	70	134	20
21	COMPRESSOR			1999	1,418		20	71	71	95	21
22	FIRE DAMPERS			1999	956		20	48	48	72	22
23	HOT WATER TANK			1999	3,891	1,245	20	195	(1,050)	325	23
24	BLINDS			1999	609		20	20	20	35	24
25	WATER CHILLER			1999	2,211	57	20	111	54	176	25
26	SIR REMODELING			1999	12,085	310	20	604	294	755	26
27	HVAC WORK			1999	1,510		20	76	76	95	27
28	HVAC WORK			1999	8,253	212	20	413	201	585	28
29	AIR CONDITIONER			1999	77,360	1,984	20	3,868	1,884	5,802	29
30	ELEVATOR WORK			1999	58,402	1,497	20	2,920	1,423	4,623	30
31	AIR COOLED CHILLER			1999	14,147	363	20	707	344	1,061	31
32	BOILER			1999	10,873	3,469	20	544	(2,925)	680	32
33	RETILE ELEVATORS			1999	4,912		20	246	246	390	33
34	HVAC WORK			1999	1,568		20	78	78	98	34
35	GLASS & DOOR			2000	1,525		20	38	38	38	35
36	TOTAL (lines 4 thru 35)				$ 273,858	$ 10,771		$ 13,648	$ 2,877	$ 22,078	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PAINT			2000	1,095		20	9	9	9	9
10	PAINT			2000	635		20	3	3	3	10
11	HVAC			2000	1,366		20	34	34	34	11
12	HVAC			2000	1,112		20	9	9	9	12
13	BOILER WORK			2000	1,605		20	53	53	53	13
14	BOILER WORK			2000	7,842		20	98	98	98	14
15	FLOORING			2000	2,786		20	139	139	139	15
16	FLOORING			2000	5,190		20	260	260	260	16
17	SCREENS			2000	1,375		20	34	34	34	17
18	CHUTE DOORS			2000	2,887		20	132	132	132	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 25,893	$		$ 771	$ 771	$ 771	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1993	ALLOC S.I.R.	$ 14,736	$ 468	35	$ 421	$ (47)	$ 3,158	4
5	`		1993	ALLOC S.I.R.	30,092	955	35	860	(95)	6,448	5
6											6
7											7
8											8
	Improvement Type**										
9	PREFERRED BKKG			1997	18,403	694	20	920	226	3,505	9
10	PREFERRED BKKG			1999	146	47	20	7	(40)	11	10
11	PREFERRED BKKG			2000	923		20	19	19	19	11
12	S.I.R.PROPERTIES-PREFERRED BKKG			1999	1,867	187	20	93	(94)	140	12
13	S.I.R.PROPERTIES-PREFERRED BKKG			1998	892	89	20	45	(44)	112	13
14	S.I.R.PROPERTIES-PREFERRED BKKG			1997	56	6	20	3	(3)	12	14
15	S.I.R.PROPERTIES-PREFERRED BKKG			1994	140	4	20	7	3	46	15
16	S.I.R.PROPERTIES-PREFERRED BKKG			1993	239	13	20	12	(1)	90	16
17	S.I.R.MANAGEMENT			1993	12,924	429	20	652	223	5,094	17
18	S.I.R.MANAGEMENT			1994	40		20	4	4	26	18
19	S.I.R.MANAGEMENT			1995	295	17	20	15	(2)	80	19
20	S.I.R.MANAGEMENT			1999	1,404	93	20	70	(23)	85	20
21	S.I.R.MANAGEMENT			2000	848	92	20	29	(63)	29	21
22	S.I.R.PROPERTIES-S.I.R.MANAGEMENT			1999	3,813	381	20	191	(190)	286	22
23	S.I.R.PROPERTIES-S.I.R.MANAGEMENT			1998	1,822	182	20	91	(91)	228	23
24	S.I.R.PROPERTIES-S.I.R.MANAGEMENT			1997	113	11	20	6	(5)	26	24
25	S.I.R.PROPERTIES-S.I.R.MANAGEMENT			1994	287	7	20	14	7	93	25
26	S.I.R.PROPERTIES-S.I.R.MANAGEMENT			1993	488	26	20	24	(2)	183	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 89,528	$ 3,701		$ 3,483	$ (218)	$ 19,671	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
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24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITA # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 312,358	$ 26,779	$ 30,988	$ 4,209		$ 163,819	37
38	Current Year Purchases	17,762	3,105	1,208	(1,897)		1,217	38
39	Fully Depreciated Assets	17,147					17,147	39
40								40
41	TOTALS	$ 347,267	$ 29,884	$ 32,196	$ 2,312		$ 182,183	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 1,532,018	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 77,189	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 89,977	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 12,788	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 398,153	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.
0037960
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

LINE 28: PRIOR YEARS

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
COLUMBUS PARK NURSING & REHABILITATION	248,332	21,928	24,739	2,811	123,422
PREFERRED BKKG	21,378	1,531	1,984	453	13,112
S.I.R.PROPERTIES-PREFERRED BKKG					
S.I.R.MANAGEMENT	42,620	3,320	4,262	942	27,264
S.I.R.PROPERTIES-S.I.R.MANAGEMENT	28		3	3	21
TOTALS	312,358	26,779	30,988	4,209	163,819

LINE 29: CURRENT YEAR

COLUMBUS PARK NURSING & REHABILITATION	15,788	2,747	1,090	(1,657)	1,090
PREFERRED BKKG	623	125	52	(73)	52
S.I.R.PROPERTIES-PREFERRED BKKG	14		1	1	10
S.I.R.MANAGEMENT	1,337	233	65	(168)	65
S.I.R.PROPERTIES-S.I.R.MANAGEMENT					
TOTALS	17,762	3,105	1,208	(1,897)	1,217

LINE 30: FULLY DEPRECIATED

COLUMBUS PARK NURSING & REHABILITATION	17,147				17,147
PREFERRED BKKG					
S.I.R.PROPERTIES-PREFERRED BKKG					
S.I.R.MANAGEMENT					
S.I.R.PROPERTIES-S.I.R.MANAGEMENT					
TOTALS	17,147				17,147

TOTALS (Should Tie to Totals on Page 13)

COLUMBUS PARK NURSING & REHABILITATION	281,267	24,675	25,829	1,154	141,659
PREFERRED BKKG	22,001	1,656	2,036	380	13,164
S.I.R.PROPERTIES-PREFERRED BKKG	14		1	1	10
S.I.R.MANAGEMENT	43,957	3,553	4,327	774	27,329
S.I.R.PROPERTIES-S.I.R.MANAGEMENT	28		3	3	21
TOTALS	347,267	29,884	32,196	2,312	182,183

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CI# 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: CONGRESS CARE CENTER

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		216		$ 1,044,630	10		3
4	Additions							4
5	TOWER RENTAL				(8,250)			5
6	TELEPHONE INCOME				(876)			6
7	TOTAL		216		$ 1,035,504 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 01/01/92
Ending 12/31/01

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$ 1,064,340
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 7,102 Description: SEE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ALLOCATION FROM PREFERRED BKKG		$	$ 2,088	17
18	ALLOCATION FROM S.I.R. MANAGEMENT			6,694	18
19	ALLOCATION FROM ECM OWNERS COUNCIL			312	19
20					20
21	TOTAL		$	$ 9,094	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, IN(# 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 14,977	$		$ 14,977	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			9,561			9,561	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			23,722			23,722	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				22,276		22,276	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-2, 39-3				350	2,312		2,662	12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-2, 39-3				710	17,535		18,245	13
14	TOTAL			$		$ 49,320	$ 42,123		$ 91,443	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	ENTERAL SUPPLIES	1,516
2	RENTALS	7,836
3	OXYGEN	6,616
4	LABORATORY	601
5	INFUSION	966
6		
7		
8		
9		
10		
		17,535

	Outside Therapies (Column 5 - Other)	Amount
1	X-RAY	480
2	RESPIRATORY THERAPY	230
3		
4		
5		
6		
7		
8		
9		
10		
		710

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CE # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 104,112	$	1
2	Cash-Patient Deposits	42,418		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,240,444		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,353		6
7	Other Prepaid Expenses	1,587		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	161,545		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,556,459	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cos	870,322		15
16	Equipment, at Historical Cost	423,253		16
17	Accumulated Depreciation (book methods)	(444,306)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 849,269	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,405,728	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 222,740	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	50,442		28
29	Short-Term Notes Payable	390,000		29
30	Accrued Salaries Payable	158,755		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,359		31
32	Accrued Real Estate Taxes(Sch.IX-B)	157,800		32
33	Accrued Interest Payable	297		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	18,500		35
	Other Current Liabilities(specify):			
36	See supplemental schedule	202,719		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,216,612	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,216,612	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,189,116	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,405,728	$ #REF!	48

*(See instructions.)

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION # 0037960 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	58,958	
Insurance Escrow	102,587	
	161,545	

OTHER CURRENT LIABILITIES:	Amount	Amount
Due to Others	175	
Due to IDPA - Audit	202,544	
	202,719	

OTHER NON CURRENT ASSETS:

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, I# 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,191,956	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,191,956	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	908,760	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(911,600)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,840)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,189,116	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	COLUMBUS PARK NURSING & REH	# 0037960	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		1,191,956
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		1,191,956
Equity(Deficit) from Page 17 Col 1		1,189,116
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		1,189,116

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITAT # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,527,171	1
2	Discounts and Allowances for all Levels	(112,837)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,414,334	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	118,880	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 118,880	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	18,582	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	48,317	19
20	Radiology and X-Ray	740	20
21	Other Medical Services	7,174	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 74,813	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	14	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	9,160	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,160	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,617,201	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,181,706	31
32	Health Care	2,460,688	32
33	General Administration	1,554,154	33
	B. Capital Expense		
34	Ownership	1,292,895	34
	C. Ancillary Expense		
35	Special Cost Centers	100,414	35
36	Provider Participation Fee	118,584	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,708,441	40
41	**Income before Income Taxes (line 30 minus line 40)****	908,760	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 908,760	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number COLUMBUS PARK NURSING & R # 0037960 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	
2	Tower Rent	8,250
3	Phone Rent	876
4	Jury Duty Pay-Offset C.N.A.Salary	34
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	9,160

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CE # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,098	2,227	$ 66,146	$ 29.70	1
2	Assistant Director of Nursing	1,840	1,958	49,897	25.48	2
3	Registered Nurses	15,372	17,781	324,887	18.27	3
4	Licensed Practical Nurses	21,348	22,938	376,836	16.43	4
5	Nurse Aides & Orderlies	81,381	85,729	632,543	7.38	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	16,527	17,411	128,612	7.39	8
9	Activity Director	1,964	2,067	21,200	10.26	9
10	Activity Assistants	10,082	10,572	60,306	5.70	10
11	Social Service Workers	5,015	5,168	49,087	9.50	11
12	Dietician					12
13	Food Service Supervisor	1,834	1,942	28,064	14.45	13
14	Head Cook	5,721	6,268	50,092	7.99	14
15	Cook Helpers/Assistants	16,696	17,606	111,862	6.35	15
16	Dishwashers					16
17	Maintenance Workers	3,827	4,143	37,840	9.13	17
18	Housekeepers	22,216	23,289	144,646	6.21	18
19	Laundry	10,435	11,174	70,644	6.32	19
20	Administrator	1,920	2,215	75,337	34.01	20
21	Assistant Administrator	1,946	2,091	32,541	15.56	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,041	6,900	66,222	9.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,452	2,864	37,083	12.95	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	228,715	244,343	$ 2,363,845 *	$ 9.67	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 1,508	1-3	35
36	Medical Director	MONTHLY	6,300	9-3	36
37	Medical Records Consultant	104	4,368	10-3	37
38	Nurse Consultant	MONTHLY	42,768	10-3	38
39	Pharmacist Consultant	MONTHLY	1,020	10-3	39
40	Physical Therapy Consultant	116	4,240	10A-3	40
41	Occupational Therapy Consultant	32	1,618	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	20	1,015	10A-3	43
44	Activity Consultant	83	3,918	11-3	44
45	Social Service Consultant	65	3,247	12-3	45
46	Other(specify)				46
47	Dietary Consultant-S.I.R.Mgt		13,800	1-3	47
48	Director of Food Services	MONTHLY	22,032	1-3	48
49	TOTAL (lines 35 - 48)	421	$ 105,834		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	10,151	$ 286,876	10-3	50
51	Licensed Practical Nurses	14,144	239,547	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	24,295	$ 526,423		53

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC. # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITA # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Augusto Beley 1/11/00 to 6/26/00	Admin.	0	$ 39,268
Martin Lee 6/27/00 to 12/31/00	Admin.	0	36,069
Jaime Lloyd	Asst. Admin.	0	32,541
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 107,878

B. Administrative - Other

Description	Amount
MANAGEMENT FEES-SEE ATTACHED	$ 457,527
MANAGEMENT SERVICE FEES-SEE ATTACHED	75,816
TOTAL (agree to Schedule V, line 17, col. 3)	$ 533,343
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
PERSONNEL PLANNERS	UC CONSULT	$ 1,463
MID AMERICA PROGRAMMING	MDS SOFTWARE	1,320
PREFERRED BOOKKEEPING	ACCOUNTING SERVICES	19,100
FR&R	ACCOUNTING SERVICES	21,105
PREFERRED BOOKKEEPING	COMPUTER SERVICES	5,184
PREFERRED BOOKKEEPING	BOOKKEEPING SERVICES	72,576
SCHWARTZ & FREEMAN	LEGAL	25,384
STONE, MAGUIRE & BENJAMIN	LEGAL	5,721
S.I.R.MANAGEMENT, INC.	DIR REGULATORY SERV	17,496
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 169,349

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 26,768
Unemployment Compensation Insurance	32,070
FICA Taxes	179,401
Employee Health Insurance	37,808
Employee Meals	25,254
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	6,444
Union Health and Welfare	66,136
Employee Benefits	11,489
TOTAL (agree to Schedule V, line 22, col.8)	$ 385,370

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	45,299
Health Care Worker Background Check	
(Indicate # of checks performed)	2,093
Yellow Pages Advertising	6,381
Licenses, Dues & Subscriptions	7,421
Advertising	2,587
ALLOCATION-PREFERRED BKKG	382
ALLOCATION-S.I.R.MANAGEMENT	1,155
ALLOCATION-ECM OWNERS COUNCIL	12
Less: Public Relations Expense	( )
Non-allowable advertising	(2,587)
Yellow page advertising	(6,381)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 56,362

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,053
ALLOCATION-PREFERRED BKKG	194
ALLOCATION-S.I.R.MANAGEMENT	626
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,873

**See instructions.

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION C # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINTING & DECORAT	1996	$ 5,760	3	$ 1,920	$ 1,920	$ 960	$	$	$	$	$	$
2	PAINTING & DECORAT	1997	13,747	3	2,291	4,582	4,582	2,292					
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 19,507		$ 4,211	$ 6,502	$ 5,542	$ 2,292	$	$	$	$	$

Facility Name & ID Number COLUMBUS PARK NURSING & REHABILITATION CENTER, INC # 0037960 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS COUNCIL LTC $6,081**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **118,584**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **25,254** Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw